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ABSTRACT

Chronic pain syndrome appears to have certain dimensions which make it unique as a disabling condition. When pain persists, the resulting anxiety and depression, others' reactions to the patient's sick role behaviors, and situational variables such as disability benefits may all contribute to the pain syndrome and complicate the rehabilitation process. Effective counseling intervention is often dependent upon the rehabilitation professional's ability to identify and understand the implications of these underlying variables. Recognizing the complexity of chronic pain syndrome, researchers favor a multidisciplinary approach to pain management. There is a vital role on such a team for the vocational rehabilitation counselor according to M. Tuck (1983) with activities that include: "disability evaluator, patient advocate, rehabilitation liaison, translator, outpatient social worker, family counselor, placement specialist and community organization worker, as well as motivator, social reinforcer and legal expert." Since the philosophy of rehabilitation is to consider the whole individual in treatment planning, it would seem that the rehabilitation counselor is in many respects especially well-suited to working effectively with individuals with complex chronic pain syndrome. More research needs to be done concerning which counseling approaches prove most effective with this population. More attention needs to be given to developing standards for treatment approaches and measuring outcomes. (LLL)

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CHRONIC PAIN PATIENTS: IMPLICATIONS FOR REHABILITATION COUNSELING

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Running Head: CHRONIC PAIN PATIENTS

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Abstract

Chronic pain, regardless of etiology, is a disabling condition in itself that must be understood and treated by rehabilitation professionals. Overviews are presented of the components of chronic pain and the problems associated with rehabilitation efforts with this population. Intervention strategies currently used with chronic pain patients are discussed.

Chronic Pain Patients: Implications for Rehabilitation Counseling

Chronic pain is a disabling condition which affects nearly 65 million Americans (National Institute of Health [NIH], 1982). The costs of this growing health problem are high, with medical expenditures estimated at $50 billion per year (Reagles, 1984). Additionally, chronic pain impacts on relationships, work activity, and associated health care costs which are difficult to assess (Reagles, 1984).

Originating with an illness or injury, chronic pain syndrome involves a psychological component as well as social and situational reinforcers which may complicate rehabilitation efforts (Tuck, 1983.) In terms of the psychological aspects of the pain experience, sufferers of chronic pain tend to get caught in a debilitating "pain-go-round" of depression and anxiety, which is difficult to manage and detrimental to the achievement of rehabilitation goals (Smoller and Schulman, 1982).

Commonly, the chronic pain patient develops learned pain behaviors which impact upon his self-image, actions, and receptiveness to counseling (Fordyce, 1973). Schmitt (1985) adds that chronic pain "represents a complex set of problems involving organic, physical, environmental and psychological factors" (p. 72).

Despite the prevalence and seriousness of this problem, Goldberg (1982) points out that little exploration of the vocational and social adjustment of these patients has been done. Rather, individuals referred to vocational rehabilitation programs will tend to be categorized in traditional or measureable terms such as "back injured" or "cancer patient". However, Goldberg (1982) emphasizes that regardless of the "official" disabling condition which necessitated referral, "the primary disability is chronic pain syndrome" (p. 279). Understanding the complex nature of chronic pain and the inherent obstacles to rehabilitation is important to professionals working with this growing population.

In this paper, the psychological, social, and situational variables related to chronic pain are explored, including a discussion of the barriers these factors may present for rehabilitation counselors. In addition, a review of counseling strategies currently being used with chronic pain patients is offered to assist

rehabilitation professionals to effectively address the special needs of this population.

Literature Review

Psychological Variables

Chronic pain may result from a number of disorders or accidents, including spinal cord injury, low back pain, headaches, cancer, and burns (Schmitt, 1985). Despite the wide range of contributing factors, chronic pain patients seem to experience many common psychological effects as a result of living with and trying to manage chronic pain day to day (Fordyce, 1973). The subjective, personal nature of pain, for example, which is not measureable or often even discernable by traditional medical diagnostics, makes chronic pain difficult to understand and leads to feelings of anxiety for the patient (Sternbach, 1987). The chronic pain patient's experience is typically not validated by others (Fordyce, 1973). Confusion and anxiety may result, related to the nature and extent of the underlying pathology (Sternbach, 1987). As opposed to acute pain, which can be understood as a meaningful warning signal from the body, chronic pain is the problem rather than a symptom (Sternbach, 1987).

A woman living with chronic pain for nearly two years described it this way:

> Living, coping with chronic pain means that it never leaves my awareness. Discomfort leads to tension, yet I struggle not to allow this to impact on my interactions with others. This in turn creates more tension, and a cycle is set into motion. Tension and irritability build to anger--rage, really--which demands to be vented somehow, often happening inappropriately or seemingly without provocation. This internal struggle is draining, and focusing full attention on anyone or anything becomes impossible. When this continues hour after hour throughout the day, it leaves me exhausted and, as a result, depressed. Health care professionals frequently add to my frustration by failing to include me in treatment planning, not considering my lifestyle and priorities in determining treatment options, and not taking time to listen to my concerns about medications, side effects, and my feelings of lost independence and control (L. Tully, personal communication, Oct. 9, 1989).

The literature on the psychological aspects of living with chronic pain echoes this patient's experience. Bergman and Werblun

(1978) recognize the debilitating aspects of chronic pain in noting that "by the time symptoms have become chronic, anxiety and depression have become interwoven into the original somatogenic or tissue damage etiology of pain" (p. 686). In addition, profiles of pain patients from the Minnesota Multiphasic Personality Inventory, which has been widely used as a tool to identify and explore psychological traits common to chronic pain patients, suggest that this population demonstrates heightened anger toward others, a reduced sense of control over their lives, and a tendency to blame others for their problems (Hollingsworth & Watson, 1980). Perhaps Smoller and Schulman (1982) describe the cyclical nature of chronic pain syndrome best in referring to the experience as getting caught on "the pain-go-round". They (Smoller and Schulman, 1982) suggest that pain is a repetitive process of new treatment, hope, renewed pain, and more disappointment, with the stressors inherent in the cycle acting to exacerbate irritability, anxiety, and ultimately the pain itself.

Social Variables

The chronic pain patient interacts continuously with others:

health care providers, family members, and employers, each of whom potentially contribute to the development and/or reinforcement of the patient's pain experience (Fordyce, 1973). Fordyce (1973) explains that "A patient intentionally or involuntarily signals to those around him that he has pain by using a set of actions termed operants. For example, a patient may describe his pain, walk and move in a guarded manner, grimace, ask for medication, call his physician for assistance, or decide that he will stay in bed" (p. 123). In this way, the pain patient sends certain messages to others about the pain experience. How others around the patient respond may in some instances actually serve to reinforce his sick role behavior and, over time, learned pain behaviors develop (Fordyce, 1973).

One example of how social situations can lead to learning a pain habit is that of the person who receives desired attention only when in pain. "The housewife who has back pain may find the systematic consequence to hurting is that her marginally attentive husband is both attentive and helpful. Her husband's help and attention may be virtually contingent on hurting" (Fordyce, 1973, p. 124 - 125). Fordyce (1973) emphasizes that in such siutations "direct treatment of the pain is not likely to be effective. Unless the underlying problem is treated, pain is likely to persist or recur" (p. 125).

Situational Factors

Worker's Compensation and disability payments are just two situational factors which commonly pose a barrier to the chronic pain patient's return to work. The obstacles presented by these financial benefits are well-documented, as are the deleterious effects of the litigation which so often is present in the vocational rehabilitation process with the industrially injured worker (Eaton, 1979; Hammonds, Brena, and Unikel, 1978; Huneke, 1982; Schlenoff, 1979). Other situational factors which commonly effect rehabilitation efforts with chronic pain patients include employers' rejection of the injured worker and prolonged periods of patient inactivity and dependence (Eaton, 1979).

Research indicated that employers tend to have a negative attitude toward hiring persons with chronic (low back pain) (Ohlshansky, 1973; Smith, 1974). Eaton (1979) reported that employers often reject injured workers, viewing them as an insurance risk and generalizing, from their injury, that they are unable to function in any work capacity. Additionally, Smith (1974) found that employers associate problems such as low productivity and absenteeism with the chronic low back pain patient.

Prolonged periods of patient inactivity and dependence may contribute to pain chronicity as well (Eaton, 1979). These variables may undermine vocational rehabilitation efforts by preventing timely intervention (Huneke, 1982). As Huneke (1982) reports, time out of work is directly related to the likelihood of never returning to work.

Summary

Chronic pain is a multifaceted combination of physical and psychological dimensions further influenced by social and situational variables. A flexible, comprehensive approach is important if the counselor hopes to identify and address all of the factors which might complicate rehabilitation efforts (Tuck, 1983). The woman whose interview appears in this paper is representative of many chronic pain patients, in that she expresses frustration with receiving fragmented care as well as not being included in their own treatment planning with traditional health care providers. As Smith and Crisler (1984) acknowledge regarding individuals with low back pain, "Since most . . . have been through several processess prior to meeting with the rehabilitation counselor, it is important to recognize that in all probability no one has presented the client with an integrated assessment of the total situation confronting the

individual" (p. 30). This suggests that rehabilitation counselors can play an important role in comprehensive treatment planning with the chronic pain population, by bridging this communication gap.

Implications for Rehabilitation Counseling

Since early experiences with medical professionals and traditional diagnostic approaches may fail to validate or resolve the patient's problems, the chronic pain patient may approach rehabilitation counseling with anger and resistance. One immediate goal, therefore, is to "gain the patient's cooperation and confidence toward rehabilitation" (Webb, 1983 p. 1057). By recognizing that chronic pain patients typically experience a great deal of frustration prior to even entering into vocational rehabilitation, the counselor may be better able to look beyond a negative first impression to, as Smith and Crisler (1984) call it, "the person beneath the symptoms" (p. 30). Clearly, rehabilitation counselors need to be knowledgeable not only about may physical bases of chronic pain and its resulting functional limitations, but also about the psychological and social factors which influence these individuals.

Counseling Strategies with Chronic Pain Patients

Primary to the experience of chronic pain are feelings of depression and helplessness (Beck, 1985). In order to help clients shift their focus away from concerns of the body to more productive goals such as those related to vocational ability, Beck (1985) recommends that the rehabilitation counselor follow the techniques of Glasser's Reality Therapy. This approach puts emphasis on the client's behavior rather than on his feelings of discomfort, depression, and helplessness, and, Beck (1985) points out, for this reason it is especially well-suited to "moving" chronic pain patients from negative self-talk ("I am in too much pain to try that") to being more productive and assuming more responsibility.

Social variables, it is recognized, can contribute to chronic pain, as does psychological stress (Sternbach, 1987). As Huneke (1982) notes "Back pain can be secondary to such things as difficulties on the job, problems with personal relations, grief over the death of a loved one, etc." (p. 15). One strategy important to effective counseling, then, is to identify such factors in the client's life. By exploring variables such as family dynamics, financial concerns, and employers' attitudes, the counselor and client can assess their potential impact on rehabilitation efforts.

Huneke (1982) recommends using the Social Readjustment Rating Questionnaire (Holmes, 1977) as one tool to help identify and assess such stressors in the client's daily life. From this basis a more comprehensive rehabilitation plan can be developed.

The importance of family dynamics / attitudes cannot be overlooked in rehabilitation planning since family members can act to reinforce chronic pain (Fordyce, 1973). Optimally, rehabilitation planning will include re-education of the family system as a goal, with members involved in identifying and supporting client goals whenever feasible (Fordyce, 1973). Such support is often a key to the client's continued participation in and success with rehabilitation services.

Specific situational variables which can impact on the success of pain patients' vocational rehabilitation include Workers' Compensation and/or disability benefits and long periods of patient inactivity. Beck (1985) recommends that, in the face of such disincentives and/or when others involved with the client attempt to frustrate rehabilitation efforts, the effective rehabilitation specialist needs to assume the role of a negotiator. Beck (1985) states "The assumption underlying the need to be a negotiator is that one or more of those professionals involved has interests to

protect that may be inimical to rehabilitation, and that concessions can be facilitated through artful negotiation" (p. 52). Acting as a negotiator, the rehabilitation counselor can work to to identify and minimize the game playing which is often promoted by the disibility benefits system, or by other professionals involved in the pain patient's rehabilitation (Beck, 1985).

Since time spent out of work has been shown to be inversely related to a successful return to employment, early intervention is key (Huneke, 1982). Fordyce (1981) recommends that educational programs and training for the pain patient preparing to return to work be kept brief. Additionally, it is important that the vocational rehabilitation counselor communicate clearly with employers regarding individuals' abilities and restrictions, in order to expedite re-employment. Huneke (1982) concurs that early intervention is critical in stating that "There is no substitute for becoming involved thirty days' post-disability versus one or two years' post-disability. The earlier the intervention, the less likelihood that chronicity will develop" (p. 16).

Conclusions

While each client's circumstances differ, chronic pain syndrome appears to have certain dimensions which make it unique as a disabling condition. When pain persists, the resulting anxiety and depression, others' reactions to the patient's sick role behaviors, and situational variables such as disability benefits may all contribute to the pain syndrome and complicate the rehabilitation process. Effective counseling intervention is often dependent upon the rehabilitation professional's ability to identify and understand the implications of these underlying variables.

Recognizing the complexity of chronic pain syndrome, researchers favor a multidisciplinary approach to pain management (Simon, 1989; Schmitt, 1985; Tuck, 1983). Tuck (1983) points out that there is a vital role on such a team for the vocational rehabilitation counselor, and says that, while activities will vary, they may include that of: "disability evaluator, patient advocate, rehabilitation liaison, translator, outpatient social worker, family counselor, placement specialist and community organization worker, as well as motivator, social reinforcer and legal expert" (p. 13).

Since the philosophy of rehabilitation is to consider the whole individual in treatment planning, it would seem that the rehabilitation counselor is in many respects especially well-suited to working effectively with individuals with complex chronic pain syndrome.

More research needs to be done around which counseling approaches prove most effective with this population. While some of the widely used intervention strategies have been presented here, chronic pain is still an evolving field. The efficacy of these strategies need to be tested, and more attention given to developing standards for treatment approaches and measuring outcomes.

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